Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS108AGC	A. BUILDING _____ B. WING _____	C 11/12/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLESTON RESIDENTIAL CARE HOTEL	2121 W CHARLESTON BLVD LAS VEGAS, NV 89102

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Initial Comments The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of a complaint investigation conducted on your facility from 7/29/09 through 11/12/09. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility was licensed for 129 Residential Facility for Group beds for elderly and disabled person and/or persons with mental illness Category II. The census at the time of the survey was 127. Two resident files were reviewed. Complaint #NV00022572 was substantiated. See Tag Y878 Complaint #NV00022503 was substantiated. See Tag Y850 The following deficiencies were identified:	Y 000		
Y 850 SS=A	449.274(1)(a) Medical Care of Resident NAC 449.274 1. If a resident of a residential facility becomes ill or is injured, the resident's physician and a member of the resident's family must be notified at the onset of the illness or at the time of the injury. The facility shall: (a) Make all necessary arrangements to secure the services of a licensed physician to treat the	Y 850		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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Y 850	Continued From page 1 resident is the resident's physician is not available. This Regulation is not met as evidenced by: Complaint #NV00022503 Based on interview and record review from 7/29/09 to 9/23/09, the facility failed to ensure the next of kin was notified when 1 of 2 residents was sent to the hospital after a fall (Resident #2). Findings include: An interview was conducted with the family of Resident #2 on 7/29/09 at 1:45 PM. The resident's family reported the resident moved into the facility on 4/21/09. The resident's sister reported she talked to her brother on 6/3/09 and called to talk to him again on 6/11/09. She was informed by the facility that the resident fell in his room on 6/5/09 and was sent to the hospital. The resident's sister reported she did not receive any notification from the facility of her brother's fall or his transfer to the hospital, and did not know her brother was in the hospital until she called the facility on 6/11/09. On 8/17/09 at 1:50 PM, the Resident Care Coordinator (RCC), Employee #1 was interviewed. The RCC admitted the facility did not contact Resident #3's sister on 6/5/09, the date the resident fell. The RCC stated she tried to call the resident's sister "several times on Monday 6/8/09" but was unable to provide documentation of the attempted calls.	Y 850		

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Y 850	Continued From page 2 The RCC provided a completed Accident Incident Report that documented Resident #2 fell on 6/5/09 at 2:15 PM. The form had a section titled "Next of kin notified," which was left blank. Interview with the RCC on 9/23/09 at 1:31 PM revealed the facility does not have a written policy related to the time frame regarding when the next of kin should be notified. The RCC stated the form should be completely filled out, as soon as possible, and that includes notifying the next of kin. The facility provided a document showing Resident #2's sister was the resident's emergency contact with her phone number. The facility also provided a "Resident's Family and Responsible Party Contact List" dated 5/7/09 and signed by Resident #3 authorizing the facility to release his medical information to his sister. The facility failed to give Resident #2's emergency contact information to the Emergency Medical Technicians, who would have provided the information to the hospital. When Resident #1's sister called the hospital on 6/11/09, the hospital would only tell her the resident was discharged on 6/9/09 but would not tell where he was discharged to. She called the facility and was told they were not aware of where Resident #1 was. On 6/15/09, the facility notified her that her brother died on 6/7/09, while he was in the hospital. Severity: 1 Scope: 1	Y 850		
Y 878 SS=G	449.2742(6)(a)(1) Medication / Change order NAC 449.2742	Y 878		

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Y 878	Continued From page 3 6. Except as otherwise provided in this subsection, a medication prescribed by a physician must be administered as prescribed by the physician. If a physician orders a change in the amount or times medication is to be administered to a resident: (a) The caregiver responsible for assisting in the administration of the medication shall: (1) Comply with the order. This Regulation is not met as evidenced by: Based on record review and interview on 8/17/09, the facility failed to ensure that 1 of 2 residents received medications as prescribed (Resident #1). Findings include: On 8/17/09, a medication technician, Employee #1, provided Resident #1's July 2009 medication administration records (MAR) for review. The MAR indicated Resident #1 did not receive her medications on 7/6/09 and 7/7/09 due to the facility not having a current filled prescription for her medications. *Omeprazole 20 mg one tablet by mouth every day in the AM Missed two AM doses on 7/6/09 and 7/7/09. *Plavix 75 mg one tablet by mouth every day in the AM Missed two AM doses on 7/6/09 and 7/7/09. *Simvastatin 40 mg one tablet at bedtime Missed 23 PM doses from 6/16/09 through 7/7/09. The medication administration record (MAR) documented medication not in. The medication delivery log documented the	Y 878		

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Y 878	Continued From page 4 medication was delivered 7/7/09. *Carbamazepine (Tegretol) 200 mg one tablet three times a day at AM, Noon, and PM Missed two AM doses on 7/6/09 and 7/7/09 Missed two Noon doses on 7/6/09 and 7/7/09 Missed one PM dose on 7/6/09 *Gabapentin (Neurontin) 300 mg one tablet in the AM. Missed two AM doses on 7/6/09 and 7/7/09. *Aggrenox 200-25 mg CPMP 12 HR take one capsule twice a day at AM and PM Missed 23 AM doses from 6/16/09 through 7/7/09 Missed 23 PM doses from 6/16/09 through 7/7/09 The medication administration record (MAR) documented medication not in. *Docusate Sodium 100 mg take one capsule twice a day at AM and PM Missed two AM doses on 7/6/09 and 7/7/09. The 7/6/09 PM dose was marked as given. The medication delivery log documented the medication was delivered 7/7/09 *Metoclopramide HCL 10 mg take one tablet twice a day at AM and PM Missed two AM doses on 7/6/09 and 7/7/09. The 7/6/09 PM dose was marked as given. The medication delivery log documented the medication was delivered 7/7/09 *Metoprolol Tartrate 25 mg take one tablet twice a day at AM and PM Missed two AM doses on 7/6/09 and 7/7/09. The 7/6/09 PM dose was marked as given. The medication delivery log documented the medication was delivered 7/7/09 *Acidophilus 35 million-25 million cell tab one tablet every day in the AM Missed two AM doses on 7/6/09 and 7/7/09 The medication delivery log documented the medication was delivered 7/7/09	Y 878		

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Y 878	Continued From page 5 *Amlodipine Besylate 10 mg one tablet daily in the AM Missed two AM doses on 7/6/09 and 7/7/09 The medication delivery log documented the medication was delivered 7/7/09 *Asprin 81 mg one tablet every day at AM Missed two AM doses on 7/6/09 and 7/7/09. The medication delivery log documented the medication was delivered 7/7/09 *Lisinopril 5 mg one tablet every day at AM Missed two AM doses on 7/6/09 and 7/7/09. The medication delivery log documented the medication was delivered 7/7/09 *Levothyroxine Sodium 50 micrograms (mcg) one tablet every day at AM Missed two AM doses on 7/6/09 and 7/7/09. The medication delivery log documented the medication was delivered 7/7/09 *Isosorbide Mononitrate 30 mg one tablet every day at AM. Missed two AM doses on 7/6/09 and 7/7/09. The medication delivery log documented the medication was delivered 7/7/09 Employee #1 provided documentation the facility had faxed the resident's doctor on 7/2/09 to request the doctor to refill the resident's prescriptions "ASAP," and the fax was initialed as faxed 7/2/09. The facility also provided a copy of a "Resident Missed or Refused Medication Notification" faxed to the doctor on 7/6/09 relating Resident #1 missed her medications on 7/6/09. The notification related, "res in need of refills requested Thurs. 7/2/09 via phone and fax." The July 2009 MAR also indicated the resident did not receive her medications on 7/7/09. The facility had evidence of a Physician Visit Form dated 7/7/09 that documented the resident saw the doctor and got her medications refilled. The	Y 878		

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Y 878	Continued From page 6 facility failed to provide documentation the physician was contacted on 7/3/09, 7/4/09, or 7/5/09 regarding the medication refill requests. During an interview on 8/17/09 at 1:05 PM, Resident #1 revealed the following: * She went without medications from 7/4/09 through 7/7/09. * She was told the doctor was out of town and "the man left in charge" did not understand her medications and therefore did not authorize the refills. * She had to stay in bed because she felt sick without her medications. * She felt she had a mini stroke due to not getting her medications for several days. * She felt 100% better after receiving her medications * She has missed her medications before, but has not missed any medications since. Based on the interview with Resident #1 on 8/26/09, her MARs from 2/11/09 through 8/13/09 were reviewed and they confirmed the resident's comments regarding missing medications on three other occasions (4/15/09, 4/16/09 and 4/29/09). The facility did not ensure medications for Resident #1 were available in the facility on four occasions from April 2009 to July 2009. Severity: 3 Scope: 1	Y 878		